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| STATEMEN                 | T OF DEFICIENCIES<br>OF CORRECTION                                         | & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA                                                              | (X2) MUI            | LTIPLE CONSTRUCTION                                                                                                                                                                                                                                                                                     | (X3) DATE                                 | O. 0938-03<br>SURVEY      |
|--------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------|
| - 47                     | - · · · · · · · · · · · · · · · · · · ·                                    | IDENTIFICATION NUMBER:                                                                                        | A. BUILD            | DING                                                                                                                                                                                                                                                                                                    |                                           | LETED                     |
|                          |                                                                            | 445427                                                                                                        | B. WING             |                                                                                                                                                                                                                                                                                                         |                                           |                           |
| NAME OF F                | ROVIDER OR SUPPLIER                                                        | · · · · · · · · · · · · · · · · · · ·                                                                         | s                   | TREET ADDRESS, CITY, STATE, ZIP COD                                                                                                                                                                                                                                                                     |                                           | 12/2013                   |
|                          | DA HEALTH CARE C                                                           |                                                                                                               |                     | 444 ONE ELEVEN PLACE<br>COOKEVILLE, TN 38501                                                                                                                                                                                                                                                            | <b>-</b>                                  |                           |
| (X4) ID<br>PREFIX<br>TAG | EACH DEFICIENCY                                                            | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)                                 | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)                                                                                                                                                                                                                | HOULD BE                                  | (X5)<br>COMPLETII<br>DATE |
| F 172<br>\$\$=C          | 483.10(j)(1)&(2) RIO<br>PROVISION OF VIS                                   | SHT TO/FACILITY<br>SITOR ACCESS                                                                               | F 172               | 2 483.10(j)(1)&(2)<br>Right To/Facility Provision of Visitor A<br>SS=C                                                                                                                                                                                                                                  | Access                                    |                           |
| - 1                      | provide immediate a following:                                             | e right and the facility must access to any resident by the                                                   |                     | Requirement: The resident will have the right and the provide immediate access to any resident following: any representative of the Secrepresentative of the State; the resident's                                                                                                                      | nt by the<br>pretary; any<br>s individual |                           |
|                          | Any representative of<br>Any representative of                             |                                                                                                               |                     | physician; and the State long term care of                                                                                                                                                                                                                                                              | ombudsman.                                |                           |
|                          | The resident's individ                                                     | •                                                                                                             |                     | Corrective Action: 1. On 2/22/13 the Activities Director me #57, resident #107, and resident #27 to it                                                                                                                                                                                                  | t with resident                           |                           |
|                          | The State long term                                                        | care ombudsman<br>ection 307 (a)(12) of the                                                                   |                     | how to contact representatives of the state term care ombudsman.  2. On 2/25/13 the Activities Director mer facility Resident Council group to inform to contact representatives of the state and care ombudsman.                                                                                       | t with the                                |                           |
|                          | advocacy system for<br>individuals (establish                              | ible for the protection and developmentally disabled led under part C of the billities Assistance and Bill of |                     | 3. On 2/25/13 the Administrator conducts with the Activity Department, Social Ser Admission Coordinator regarding the nee the residents on how to contact represents state and the long-term care ombudsman.  4. The facility Activity Director and Activity illuminator for compliance through months. | vices, and the ad to inform stives of the |                           |
|                          | advocacy system for                                                        | ble for the protection and<br>mentally ill individuals<br>the Protection and Advocacy<br>uals Act);           | :                   | with resident council representatives as w<br>quarterly interviews with residents. Will I<br>Findings will be reviewed in Quality Assu<br>Committee.                                                                                                                                                    | ell as                                    | ·                         |
| 10                       | Subject to the resider<br>consent at any time, i<br>elatives of the reside | nt's right to deny or withdraw immediate family or other ent, and                                             |                     |                                                                                                                                                                                                                                                                                                         |                                           | 02/25/13                  |
| r.                       | esident's right to den                                                     | e restrictions and the<br>y or withdraw consent at any<br>visiting with the consent of                        |                     |                                                                                                                                                                                                                                                                                                         |                                           |                           |
| a                        | ny resident by any er                                                      | ide reasonable access to ntity or individual that                                                             |                     |                                                                                                                                                                                                                                                                                                         |                                           |                           |
| maturyid<br>d            | IRECTOR'S OR PROVIDER                                                      | VSUPPLIER REPRESENTATIVE'S SIGNA                                                                              | TURE                | ADMINISTANTOR                                                                                                                                                                                                                                                                                           |                                           | K6) DATE                  |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

| STATEMEN                 | T OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | THE SERVICES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <del></del>        |     |                                                                                                | OMB N    | <u>40. 093</u> 8-03       | 9  |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|-----|------------------------------------------------------------------------------------------------|----------|---------------------------|----|
| AND PLAN                 | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) N<br>A. Bül   |     | TIPLE CONSTRUCTION ING                                                                         | (X3) DAT | E SURVEY<br>IPLETED       | _  |
| NAME OF F                | 2001855                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 445427                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | B. WIN             | ۷G. |                                                                                                | 0:       | 2/12/2013                 |    |
|                          | PROVIDER OR SUPPLIER<br>DA HEALTH CARE CE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                    | į , | REET ADDRESS, CITY, STATE, ZIP CODE<br>444 ONE ELEVEN PLACE<br>COOKEVILLE, TN 38501            |          |                           |    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFI<br>TAG | x   | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE   | (X5)<br>COMPLETIO<br>DATE | N. |
|                          | This REQUIREMEN' by: Based on medical rethe facility failed to provide the provide three residents interview. The findings included Medical record review Data Set (MDS) date resident #57 revealed the brief interview for indicating the resident interview with resident at 4:06 p.m., in the resident #107 revealed the provide th | ial, legal, or other services to to the resident's right to deny at any time.  T is not met as evidenced ecord review and interview rovide notification of access the state and the (#57, #107, and #27) of viewed.  It:  It of a quarterly Minumum of December 20, 2012, for it the resident scored a 15 on mental status (BIMS), it was cognitively intact.  It #57 on February 4, 2013, sident's room, revealed informed on how to contact estate or the ombudsman.  If of a quarterly Minumum is November 12, 2012, for differential status (BIMS), was cognitively intact.  It #107 on February 6, 2013, sident's room, was not informed on how to how to sident's room, was not informed on how to how to sident's room, was not informed on how to how to how to sident's room, was not informed on how to how to how to informed on how to how to how to informed on how to how to how to how to informed on how to how to how to informed on how to how to how to informed on how to how to how to how to informed on how to how t | F1                 | 72  |                                                                                                |          |                           |    |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    | 1   |                                                                                                |          | i                         | 1  |

DEFAR IMERI OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER-COMPLETED A. BUILDING B. WING 445427 02/12/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BETHESDA HEALTH CARE CENTER 444 ONE ELEVEN PLACE COOKEVILLE, TN 38501 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC (DENTIFYING INFORMATION) TAG DATE DEFICIENCY) F 172 | Continued From page 2 F 172 Medical record review of a quarterly Minumum Data Set (MDS) dated January 2, 2013, for resident #27 revealed the resident scored a 15 on the brief interview for mental status (BIMS), indicating the resident was cognitively intact. Interview with resident #27 on February 6, 2013, at 10:30 a.m., in the resident's room, revealed the resident was not informed on how to contact representatives of the state or the ombudsman Interview with the Activity Director and the Activity Assistant on February 6, 2013, at 2:44 p.m., in the dining room, revealed the resident's access to representatives of the state or the ombudsman had not been discussed with any of the residents, nor had it been discussed during any resident council meetings. 483.13(a) RIGHT TO BE FREE FROM F 221 483.13(a) SS=D PHYSICAL RESTRAINTS Right To Be Free From Physical Restraints The resident has the right to be free from any physical restraints imposed for purposes of Requirement; The facility will ensure that a resident has the right to discipline or convenience, and not required to be free from any physical restraints imposed for treat the resident's medical symptoms. purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced Corrective Action: by: 1. On 2/7/13 the Director of Nursing obtained a new Based on medical record review, observation, order for a reclined gerichair for resident #30. A preand interview, the facility failed to assess for the restraint assessment was completed and informed consent obtained from family by the Director of use of a restraint for one resident (#30) of three Nursing on same day. residents reviewed for the use of physical 2. On 2/22/13 Director of Nursing and Staffing restraints. Coordinator conducted visual audits of residents in reclined gerichairs to ensure proper documentation and assessment of potential restraint usage. The findings included:

DEFARTMENT OF HEALTH AND HUMAN SERVICES

| L CEN                   | TERS FOR MEDICARI                                                                                                                                                                                                           | E & MEDICAID SERVICES                                                                                                                                                                                                                                                                                                                                          |                   |                |                                                                                                                                                                                                                                                                                                                                                                                                          | FORM                                                                       | MAPPROVED                  |
|-------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------|
| ISTATE                  | SENT OF DEFICIENCIES<br>AN OF CORRECTION                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                          |                   | MULT           | TIPLE CONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                       | (X3) DATE S                                                                |                            |
| ]                       |                                                                                                                                                                                                                             | 445427                                                                                                                                                                                                                                                                                                                                                         | B. W              |                | <del></del>                                                                                                                                                                                                                                                                                                                                                                                              |                                                                            |                            |
| NAME                    | OF PROVIDER OR SUPPLIER                                                                                                                                                                                                     | 110427                                                                                                                                                                                                                                                                                                                                                         |                   | <del>_</del> _ |                                                                                                                                                                                                                                                                                                                                                                                                          | 02/1                                                                       | 2/2013                     |
| BETH                    | ESDA HEALTH CARE C                                                                                                                                                                                                          | ENTER                                                                                                                                                                                                                                                                                                                                                          |                   | ] 4            | REET ADDRESS, CITY, STATE, ZIP CODE<br>144 ONE ELEVEN PLACE<br>COOKEVILLE, TN 38501                                                                                                                                                                                                                                                                                                                      |                                                                            |                            |
| (X4) (I<br>PREFI<br>TAG | X   (EACH DEFICIENC)                                                                                                                                                                                                        | NTEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                             | ID<br>PREF<br>TAG | ıx             | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)                                                                                                                                                                                                                                                                                                         | HIDRE                                                                      | (X5)<br>COMPLETION<br>DATE |
| F 22                    | Resident #30 was a November 27, 2012 Subdural Hematom Wasting, Congestiv Medical record reviet dated January 13, 2 (reclining chair) for a Observation on Febrevealed the resident hallway seated in a pobservation on Febr | idmitted to the facility on the facility on the diagnoses including a, Dementia, Muscular e Heart Failure, and Anemia.  Bew of a physician's order 013, revealed "geri chair of (patient)"  Fruary 4, 2013, at 12:48 p.m., at was sitting in the 500 reclined geri chair. Continued uary 7, 2013, at 8:16 a.m., at was sitting in the 500 reclined geri chair. | F                 | 221            | 3. On 2/23/13 the Staffing Coordinator concinservicing with nursing personnel regarding observation and assessment for potential resolution of residents.  4. The Director of Nursing, Assistant Direct Nursing, and Staffing Coordinator to monitoe compliance through weekly observations X3 compliance is maintained decrease audits to X3 months. Findings will be reviewed in Quastrance Committee. | g the proper<br>straints.<br>n of change<br>or of<br>or for<br>80 days. If | 02/23/13                   |
|                         | on February 7, 2013, resident's room, contunable to upright the "it is in a locked red metal bar attached to                                                                                                                | ted Practical Nurse (LPN) #1 , at 8:43 a.m., outside the firmed the resident was geri chair. LPN #1 stated clined position (pointed to a the back of the geri chair) an be uprighted, but this one                                                                                                                                                             |                   |                |                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                            |
| F 248<br>SS=D           | office, confirmed the upright the geri chair assess the use of a resident #30. 483.15(f)(1) ACTIVIT                                                                                                                         | ector of Nursing (DON) on<br>9:32 a.m., outside the DON<br>resident was unable to<br>and the facility had failed to<br>estraint prior to use for<br>IES MEET<br>OF EACH RES                                                                                                                                                                                    | ·<br>F 24         | ۷              | 483.15(f)(1) Activities Meet Interests/Needs of Each Resid SS=D                                                                                                                                                                                                                                                                                                                                          | ent ¦                                                                      |                            |
|                         | of activities designed the comprehensive as                                                                                                                                                                                 | ide for an ongoing program<br>to meet, in accordance with<br>ssessment, the interests and<br>and psychosocial well-being                                                                                                                                                                                                                                       |                   |                | Requirement: The facility will ensure that an ongoing progra activities is designed to meet, in accordance we comprehensive assessment, the interests and the physical, mental, and psychosocial well-being.                                                                                                                                                                                             | ith the                                                                    |                            |

### CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED

|   | STATEMEN                 | IT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | A INCOICAID SERVICES                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                    |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | OMB N                                                                                | O. 0938-039                | 9. |
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|   | AND PLAN                 | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) M<br>A. BU    |     | TIPLE CONSTRUCTION NG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X3) DATE                                                                            | SURVEY<br>PLETED           | -  |
| ļ |                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 445427                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | B. Wil             |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                      | H-0/004.0                  |    |
| l | NAME OF I                | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                    |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <u> </u>                                                                             | /12/2013                   | _  |
|   | BETHES                   | DA HEALTH CARE C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                    | 4   | REET ADDRESS, CITY, STATE, ZIP CODE<br>144 ONE ELEVEN PLACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | -                                                                                    |                            |    |
| _ |                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | · · · · · · · · · · · · · · · · · · ·                                                                                                                                                                                                                                                                                                                                                                                                                                   |                    | (   | COOKEVILLE, TN 38501                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                      |                            |    |
| _ | (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPROPRIES OF THE APP | ULD BE                                                                               | (X5)<br>COMPLETION<br>DATE | '  |
|   |                          | of each resident.  This REQUIREMEN by: Based on medical read interview, the fact activities to meet the of thirty-eight resider.  The findings included Resident #97 was ad 16, 2008, with diagnot (Hypertension), Hypertension), Hypertension), Hypertension), Hypertension, Hypertension | T is not met as evidenced ecord review, observation cility failed to provide needs of one resident (#97) its reviewed.  It: Imitted to the facility on April oses including HTN othyroidism, Hyperglycemia, Cytosis, Alzheimer's and Anemia.  If of the care plan dated May dependent of January 15, 2014 (2013), and resident will engage in the resident will engage in the residents at least once courage resident to provide alizationinvite resident to incourage | F2                 | 248 | Corrective Action;  1. On 2/13/13 Activity Director ensured m turned on for resident #97 in her room after 2. On 2/22/13 Activity Director conducted residents who receive one-on-one activities needs were being appropriately met.  3. On 2/25/13 inservice was conducted by Administrator to Activity Director and Activity Assistant regarding the importance of devel appropriate one-on-one activities. On 2/25/conducted by Activity Director with front-fir regarding the need to turn on music in residing monitor for compliance through weekly obstactive of the compliance is maintained decretor monthly X6 months. Findings will be revenually Assurance Committee.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | r meals. audit of to ensure  vity oping '13 inservice ine staff ent #97's  tant will | 02/25/13                   |    |
|   | S                        | 0:05 a.m., February 6,                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2013, at 10:35 a.m., and                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                      |                            |    |

DEPARTMENT OF REALTH AND HUMAN SERVICES

| CENT                     | ERS FOR MEDICARI                                                                                                                                                                                                                                                                                                                                                                                                               | & MEDICAID SERVICES                                                                                                                                                                                  |                   |     |                                                                                                  | OMB t     | RM APPROVE <b>⊡</b><br><u>VO. 0938</u> -0391 |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|-----|--------------------------------------------------------------------------------------------------|-----------|----------------------------------------------|
| AND PLAN                 | NT OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                | (X2) I            |     | TIPLE CONSTRUCTION                                                                               | (X3) DAT  | VO. 0936-0391<br>E SURVEY<br>PLETED          |
| <u> </u>                 |                                                                                                                                                                                                                                                                                                                                                                                                                                | 445427                                                                                                                                                                                               | B, WI             |     |                                                                                                  |           | •                                            |
| NAME OF                  | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                      |                   |     |                                                                                                  |           | 2/12/2013                                    |
|                          | SDA HEALTH CARE C                                                                                                                                                                                                                                                                                                                                                                                                              | ENTER                                                                                                                                                                                                |                   | 1   | REET ADDRESS, CITY, STATE, ZIP COO<br>444 ONE ELEVEN PLACE<br>COOKEVILLE, TN 38501               | E         |                                              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                               | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                                                                          | ID<br>PREF<br>TAG | ΙX  | PROVIDER'S PLAN OF CORP<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE                   |
|                          | the resident was in a music or television particle. Telephone interview on February 5, 2013 like resident to have stimulation.  Observation of the reat 10:05 a.m., in the resident in the activitia singing activity.  Interview with the Act 6, 2013, at 10:30 a.m. nursing station, rever activities 4-5 times a "becauselikes singilattended with the resident in the resident in the activities CD player inroom finustc" | uary 7, 2013, at 8:45 a.m.,<br>5 p.m., revealed each time<br>a guiet resident room with no                                                                                                           |                   | 248 |                                                                                                  |           |                                              |
|                          | revealed the activity ke was involved in "one of days between Novem 29, 2013, (seventy da confirmed music was activity for the resider certified nursing assisting tructed to turn the resident.                                                                                                                                                                                                                               | ogs indicated the resident on one" activities on twelve liber 21, 2012 and January lys). Further interview the most appropriate and unit staff (nurses and stants) had not been CD player on for the |                   |     |                                                                                                  | i         |                                              |
| F 279   4                | 483.20(d), 483.20(k)(<br>COMPREHENSIVE C                                                                                                                                                                                                                                                                                                                                                                                       | 1) DEVELOP<br>ARE PLANS                                                                                                                                                                              | F 279             | 3   | 483.20(d) 483.20(k)(1)                                                                           |           |                                              |

SS=D

# CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

| STATEMEN      | IT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | CAN DECISION SERVICES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <del> </del>          | <u> </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | OMB N                                                                                                                                                              | O. 0938-039                |
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| AND PLAN      | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X2) MUL<br>A. BUILDI | TIPLE CONSTRUCTION ING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X3) DATE                                                                                                                                                          |                            |
| <del></del>   | <del></del>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 445427                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | B. WING               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                    | 14010040                   |
| NAME OF       | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 51                    | REET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 02/                                                                                                                                                                | 12/2013                    |
| BETHES        | SDA HEALTH CARE C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                       | 444 ONE ELEVEN PLACE<br>COOKEVILLE, TN 38501                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                    |                            |
| (X4) ID       | SUMMARY STA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | I ID                  | PROVIDER'S PLAN OF CORRE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | OTION                                                                                                                                                              | <del></del>                |
| PREFIX<br>TAG | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | PREFIX<br>TAG         | (EACH CORRECTIVE ACTION SH<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | OULD RE                                                                                                                                                            | (X5)<br>COMPLETION<br>DATE |
| F             | A facility must use to develop, review a comprehensive plan. The facility must develop for each reside objectives and timet medical, nursing, an needs that are identical assessment.  The care plan must of to be furnished to atthe highest practicable possible possible required under §483.25; and any selective for the resident's §483.10, including the under §483.10(b)(4).  This REQUIREMENT by:  Based on medical replan for two residents reviewed.  The findings included residents residents reviewed.  The findings included residents reviewed. | the results of the assessment and revise the resident's a of care.  I velop a comprehensive care at that includes measurable ables to meet a resident's dimental and psychosocial affed in the comprehensive describe the services that are tain or maintain the resident's hysical, mental, and ing as required under revices that would otherwise 83.25 but are not provided exercise of rights under e right to refuse treatment  The is not met as evidenced cord review and interview vise a comprehensive care (#57 and #97) of thirty-eight | F 279                 | Requirement: The facility will use the results of the asso develop, review and revise the resident's comprehensive plan of care. The facility comprehensive care plan for each resident measurable objectives and timetables to medical, nursing, and mental arpsychosocial needs.  Corrective Action: 1. On 2/25/13 the care plan for resident #updated to reflect that the resident had bro decayed teeth. On 2/25/13 the care plan for was updated to reflect that the resident had have music on a CD player played in their meals. 2. On 2/25/13 MDS coordinators reviewe for accuracy of care plans. Ongoing. 3. On 2/25/13 inservice was conducted by Administrator with the MDS Coordinators the need to have accurate information refleresidents care plans. 4. The facility MDS Coordinators will ass the accuracy of residents care plans. Finding reviewed in Quality Assurance Committee. | will develop a t that includes neet a and  57 was ken and or resident #97 d a desire to room after d residents the regarding xted in the ess quarterly nes will be | 02/25/13                   |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 02/14/2013 FORM APPROVED

|   | STATEMEN                 | NT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | A MEDICAID SERVICES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                     | <del> </del>                                                                                                           | OMB N     | O. 0938-0391               |
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| İ | AND PLAN                 | OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MU<br>A. BUILO | LTIPLE CONSTRUCTION<br>DING                                                                                            | (X3) DATE | SURVEY<br>LETED            |
| i |                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 445427                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | B. WING             |                                                                                                                        |           |                            |
|   |                          | PROVIDER OR SUPPLIER<br>SDA HEALTH CARE CH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | s                   | TREET ADDRESS, CITY, STATE, ZIP CODE<br>444 ONE ELEVEN PLACE<br>COOKEVILLE, TN 38501                                   | 02        | /12/2013                   |
|   | (X4) ID<br>PREFIX<br>TAG | (CACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHO<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP.<br>DEFICIENCY) | DULD RE   | (XS)<br>COMPLETION<br>DATE |
|   |                          | (MDS) dated June 4 had "obvious or lik teeth"  Medical record revie updated February 6, had not been updated decayed teeth  Interview with the Lic February 11, 2013, a care plan was not up had broken and decayed broken and decayed teeth.  Resident #97 was ad 16, 2008, with diagnor Hypothyroidism, Hype Psychosis, Delusions Disturbance, Palpitati Leukocytosis, Alzhein and Anemia.  Medical record review (MDS) dated May 15, activity was very imported to the control of the cont | ely cavity or broken natural  w of a facility Care Plan, last 2013, revealed the care plan d to reflect broken and  ensed Practical Nurse #1, on t 10:25 a.m., confirmed the dated to indicate the resident yed teeth.  mitted to the facility on April ses including Hypertension, erglycemia, Dementia, Depression with Behavioral ons, Osteoarthritis, ner's Disease, Dysphagia,  of the Minimum Data Set 2012, revealed music rtant to him/her.  of the care plan dated May I January 15, 2014 (2013), at risk for social isolation interest in participating in al resident will engage in residents at least once encourage resident to ram to provide izationinvite resident to | F 279               |                                                                                                                        |           |                            |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| _CENT                    | ERS FOR MEDICARE                                                                                                           | AND HUMAN SERVICES  & MEDICAID SERVICES                                                                                                                                                |                    |                                                                                                                                  | FOR                            | MAPPROVED                  |
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| SIATEM                   | ENT OF DEFICIENCIES<br>N OF CORRECTION                                                                                     | (X1) PROVIDER/SUPPLIER/CHA                                                                                                                                                             | OX23 N             | AULTIPLE CONSTRUCTION                                                                                                            | OMB N                          | <u> 0938-0391</u>          |
| 1 210 1 1                | OF CORRECTION                                                                                                              | IDENTIFICATION NUMBER:                                                                                                                                                                 |                    | ILDING                                                                                                                           | (X3) DATE<br>COMP              | LETED                      |
|                          | ·                                                                                                                          | 445427                                                                                                                                                                                 | B. Wit             | NG                                                                                                                               | 02/                            | 12/2013                    |
|                          | PROVIDER OR SUPPLIER<br>SDA HEALTH CARE CI                                                                                 | ENTER                                                                                                                                                                                  |                    | STREET ADDRESS, CITY, STATE, ZIP CO<br>444 ONE ELEVEN PLACE<br>COOKEVILLE, TN 38501                                              |                                | 12/20/13                   |
| (X4) ID<br>PREFIX<br>TAG | I LEACH DEFICIENCY                                                                                                         | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                                                                                                            | ID<br>PREFI<br>TAG | PROVIDER'S PLAN OF CO<br>X (EACH CORRECTIVE ACTION                                                                               | I SHOU D RE                    | (X5)<br>COMPLETION<br>DATE |
| F 279                    | residentprovide re<br>calendar of activities<br>refuse"  Medical record revie<br>Review Progress No<br>revealed "2-3 times | ge 8 sident and family with srespect resident's right to w of the Quarterly Activity tes dated January 9, 2013, s monthsingersCD in nmusic activities weekly if                        | F 2                | 79                                                                                                                               |                                |                            |
|                          | 6, 2013, at 10:30 a.m<br>nursing station, revea<br>activities 4-5 times a<br>"becauselikes singi<br>attended with the res  | tivities Assistant on February, in the hallway at the south aled the resident goes to month, usually singing ng," the spouse atways ident and stated "there is a or music becauselikes |                    |                                                                                                                                  |                                |                            |
| į                        | Medical record review<br>February 6, 2013, rev<br>music or to turn on C                                                    | of the care plan dated<br>ealed no care planning for<br>D player.                                                                                                                      |                    |                                                                                                                                  |                                |                            |
| F 282<br>SS=D            | 7, 2013, at 12:23 p.m. confirmed the care pla                                                                              | ive activities involving music<br>er in the room.<br>ICES BY QUALIFIED                                                                                                                 | F 282              | 2 483.20(k)(3)(ii) Services BY Qualified Persons/Per Care SS=D                                                                   | Plan                           |                            |
|                          | must be provided by a                                                                                                      | or arranged by the facility<br>ualified persons in<br>resident's written plan of                                                                                                       |                    | Requirement: The services provided or arranged by the provided by qualified persons in accordances ident's written plan of care. | facility will be nee with each |                            |

This REQUIREMENT is not met as evidenced

DEFARTIMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC

| <b>シデルン</b>              | TIMENT OF REALT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | AND HUMAN SERVICES                                                                                                                                                                                                                                                                                                                                                                           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| CENTE                    | RS FOR MEDICARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | & MEDICAID SERVICES                                                                                                                                                                                                                                                                                                                                                                          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        | M APPROV                                 | ÆD.      |
| IOINIEMEN                | IT OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) M              |    | TIPLE CONSTRUCTION                                                                                                                                                                                                                                                                                                 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        | O. 0938-03                               | 391      |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 445427                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | B. WIN              |    | <del> </del>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | /d.0.100.40                              |          |
| NAME OF                  | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                              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        | /12/2013                                 | $\dashv$ |
| BETHES                   | DA HEALTH CARE C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     | 4  | REET ADDRESS, CITY, STATE, ZIP CODE<br>144 ONE ELEVEN PLACE<br>COOKEVILLE, TN 38501                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                      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| (X4) ID<br>PREFIX<br>TAG | {EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG |    | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 91 D RE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X5)<br>COMPLETIO<br>DATE                | JK<br>IK |
|                          | and interview, the farcare by a qualified policy (#135) and failed to the monitoring Vitamin Dof thirty-eight resider. The findings included Resident #135 was a 5, 2011, with diagnost (after) Fall, Hypertens Depression, and Sev Disease.  Medical record review Data Set (MDS) dated revealed the resident assistance with all act and was severely cognoses on the resident in a reclined resident in a reclined resident on February (revealed the resident in the hallway outside of was alert, however disposervation of the resident two upper front technic two upper front technic and worn down. | on, medical record review cility failed to provide dental rofessional for one resident roflow the care plan for plevels for one resident (#52) its reviewed.  di:  dmitted to the facility on May resident in the care plan for plevels for one resident (#52) its reviewed.  di:  dmitted to the facility on May resident in the care plan facility on May resident in the resident of the care plan facility on May resident on February 6, 2013, at 9:00 a.m., revealed the care plan facility in the resident of the care plan facility in the resident's room and plan facility in the resident's room and plan facility in the mouth rether plan facility in the mouth rether plan facility in the mouth rether plan facility in the pottom of the mouth rether plan facility in the pottom of the mouth rether plan facility in the pottom of the mouth rether plan facility in the pottom of the mouth rether plan facility in the pottom of the mouth rether plan facility in the pottom of the mouth rether plan facility in the pottom of the mouth rether plan facility in the pottom of the mouth rether plan facility in the pl |                     |    | Corrective Action:  1. (a) On 277/13 Social Worker made arrar resident #135 to be seen by a dentist. On 2 dentist at facility to see resident #135.  (b) On 277/13 lab work was ordered for concerning Vitamin D levels. On 2/8/13 re work was received by facility. On 2/8/13 p notified and new orders were noted.  2. (a) On 2/22/13 Social Services Director 1 audit of residents to ensure that residents widental intervention were identified to be see (b) On 2/22/13 Director of Nursing performed fresidents with Vitamin D deficiencies to ethere were appropriate diagnosis and labs we ordered/received/ and processed timely.  3. On 2/25/13 inservice was conducted by Administrator with Social Services Director need to have residents seen timely by dentist 2/22/13 inservice was conducted by Director with nursing personnel concerning the proper monitoring of residents with Vitamin D defice.  4. (a) The facility Social Services Director we complete monthly audits X4 months, if complianted decrease audits to quarterly. Find be reviewed in Quality Assurance Committee (b) The facility Director of Nursing and A Director of Nursing will complete weekly audity, if compliance is maintained decrease aumonthly X3 months. Findings will be reviewed Quality Assurance Committee | resident #52 resid |                                          |          |

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/14/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445427 02/12/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BETHESDA HEALTH CARE CENTER 444 ONE ELEVEN PLACE COOKEVILLE, TN 38501 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 10 F 282 Continued medical record review of the resident's care plan dated March 14, 2012, revealed ...Social Services referral for dental consult r/t (related to) missing teeth/carries..." Continued review of the resident's medical record revealed no documentation of a dental consult provided or of the resident being examined by a dentist. Interview with Social Services on February 6, 2013, in the hallway outside of the Main Dining room, at 10:25 a.m., confirmed the resident had not been seen by a dentist after the referral was made and, "...it's my fault...it didn't get done..." Resident #52 was admitted to the facility on March 2, 2005, with diagnoses including Dementia with Psychosis, Parkinson's, Hypertension, Atherosclerotic Heart Disease, Anemia, Congestive Heart Failure, Arthritis, Bundle Branch Block, Conjunctivitis, Constipation, Tremors, Degenerative Joint Disease, and Vitamin D Deficiency. Medical record review of physician orders dated October 13, 2012, revealed "Vitamin D 2,000 IU (International Units) po (by mouth) qday (every day)...Add dx: (diagnosis), Vit (Vitamin) D deficiency..."

Medical record review of a Progress Note dated October 13, 2012, revealed"...osteoporosis s/p

(status post) hip fx (fracture)...OA (osteoarthritis)...Add vit D ...

DEPARTMENT OF HEALTH AND HUMAN SERVICES CANDIED: UZ/14/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING 445427 02/12/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BETHESDA HEALTH CARE CENTER 444 ONE ELEVEN PLACE COOKEVILLE, TN 38501 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 282 Continued From page 11 F 282 Medical record review of the Care Plan dated December 5, 2012, revealed, "...resident at risk for low Vitamin D levels placing at risk for problems with weak bones...goal, Vitamin D level will be wnl (within normal limits)...interventions, med (medication) as ordered...labs as ordered..." Medical record review of the physician's orders revealed no order for Vitamin D levels. Interview with the DON (Director of Nursing,) and the ADON (Assistant Director of Nursing), on February 7, 2013, at 10:30 a.m., in the DON office confirmed the facility failed to obtain a physician's order for Vitamin D levels as care planned. 483.25(d) NO CATHETER, PREVENT UTI, F 315 F 315 483,25(d) SS=D RESTORE BLADDER No Catheter, Prevent UTL Restore Bladder SS≒D Based on the resident's comprehensive assessment, the facility must ensure that a The facility will ensure that a resident who enters resident who enters the facility without an the facility without an indwelling catheter is not indwelling catheter is not catheterized unless the catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; resident's clinical condition demonstrates that and a resident who is incontinent of bladder will catheterization was necessary; and a resident receive appropriate treatment and services to prevent who is incontinent of bladder receives appropriate urinary tract infections and to restore as much normal treatment and services to prevent urinary tract bladder function as possible. infections and to restore as much normal bladder function as possible. Corrective Action: On 2/23/13 Director of Nursing completed a bladder assessment on resident #30. This REQUIREMENT is not met as evidenced 2. On 2/23/13 Director of Nursing conducted audit of residents who declined, were newly admitted, or reby: admitted to facility for appropriate bladder assessment Based on medical record review, observation, 3. On 2/23/13 inservice conducted by Director of and interview the facility failed to complete a

residents reviewed.

bladder assessment for one resident (#30) of 38

facility.

Nursing with nursing personnel regarding the proper

completion of bladder assessments for residents who declined, were newly admitted, or re-admitted to the DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DESICENCIES AND PLAN OF CORRECTION  MARE OF PROVIDER OR SUPPLIER  BETHESDA HEALTH CARE CENTER  SUMMAY STATEMENT OF DEPICIENCIES PREFIX TAG  SUMMAY STATEMENT OF DEPICIENCIES ECAND EPICENCY MIST SE PRECEDED BY FULL RESOLATORY OR LSC IDENTIFYING INFORMATION)  FOR 315  Continued From page 12  The findings included:  Resident #30 was admitted to the facility on January 1, 2013, with diagnoses including Congestive Heart Failure, Alzheimer's Disease, Dysphagela, Amerias, Returnated Arthritis, Exophageal Reflux, Insormal, Chronic Kidney Disease, Lupus, and Vitamin Dietciency.  Medical record review of the admission assessment revealed the resident was admitted to the hospital from December 11, 2012, to January 1, 2013.  Medical record review of the Admission Minimum Data Set (MDS) dated December 4, 2012, revealed the resident was admitted to the hospital from December 17, 2013, revealed the resident was admitted to the hospital from December 17, 2013, revealed the resident was admitted to the hospital from December 17, 2013, revealed the resident was requirely incombinent (7 or more episodes of urinary incombinence).  Observation and interview with the resident on February 9, 2013, at 7:55 a.m., on the 600 hallway, revealed the resident was requirely incombinent (7 or more episodes of urinary incombinence).  Interview with certified nurse assistant, (CNA) #1 on February 11, 2013, at 4:25 p.m. on 600 hall revealed, CNAs check on the resident wavery 2 hours, and "lately the resident had been continent with assistance from the CNA."  Interview with MDS Coordinator #1 on February 11, 2013, at 4:05 p.m., in the MDS                                                                                                                                                                                                                                                                                                                                                                                                                     |   | STATCHERL | T 00 DEBUTE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | DERVICEO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |            |     |                                                                                                                                    | OWR M                | <u>O. 0938-03</u> | 91 |
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| MAKE OF PROVIDER OR SUPPLIER  BETHESDA HEALTH CARE CENTER  O(1) DESCRIPTION OF THE PRECEDED BY FULL REGULATORY OR SUPPLIED THE PREPORTANTE OF THE SUPPLIED THE | j | AND PLAN  | I OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ı          |     |                                                                                                                                    |                      |                   |    |
| BETHESDA HEALTH CARE CENTER  (A4) DI  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION)  F 315  Continued From page 12  The findings included:  Resident #30 was admitted to the facility on January 1, 2013, with diagnoses including Congestive Heart Failure, Alzheimer's Disease, Dysphagia, Anema. Rheumatoid Arthritis, Esophageal Reflux, Insomina, Chronic Kidney Disease, Lupus, and Vitamin D Deficiency.  Medical record review of the Admission Minimum Data Set (MDS) dated December 1, 2012, to January 1, 2013.  Medical record review of a significant change MDS dated January 7, 2013, revealed the resident was admitted to the hospital from December 11, 2012, bu January 1, 2013.  Medical record review of a significant change MDS dated January 7, 2013, revealed the resident was frequently inconfinent (7 or more episodes of urinary inconfinence).  Observation and interview with the resident on February 8, 2013, at 7:55 a.m., on the 600 hallway, revealed the resident in a gerichal rand very confused.  Interview with certified nurse assistant, (CNA) #1 on February 11, 2013, at 4:25 p.m. on 600 hall revealed, CNAs check on the resident every 2 hours, and "lately the resident had been continent with assistance from the CNA"  Interview with MDS Coordinator #1 on February  Interview with MDS Coordinator #1 on February                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Į |           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 445427                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | B. WIN     | ŧG_ |                                                                                                                                    | 02                   | IA DIDAAD         |    |
| SETHESDA HEALTH CARE CENTER   44 0 ME ELEVEN PLACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |   | NAME OF F | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ·          | STF | REET ADDRESS, CITY, STATE, ZIP CODE                                                                                                | <u>  U2</u>          | 11212013          | _  |
| PREFIX FACTOR PLANT OF DEPICIENCES PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 315  Continued From page 12  The findings included:  Resident #30 was admitted to the facility on January 1, 2013, with diagnoses including Congestive Heart Failure, Alzierimer's Disease, Dysphagia, Anemia, Rheumahoid Arthritis, Esophageal Reflox, Insomnia, Chronic Kidney Disease, Lupus, and Vitamin D Deficiency.  Medical record review of the admission assessment revealed the resident was admitted to the hospital from December 1, 2012, to January 1, 2013.  Medical record review of the Admission Minimum Data Set (MDS) dated December 4, 2012, revealed the resident was admitted to the hospital from December 1, 2012, to January 7, 2013, revealed the resident was frequently incontinent (7 or more episodes of urinary incontinence).  Observation and interview with the resident on February 7, 2013, at 4:25 p.m. on 600 hall revealed. CNAs check on the resident every 2 hours, and "lately the resident had been continent with assistance from the CNA."  Interview with MDS Coordinator #1 on February 1 interview with MDS Coordinator #1 on February 4. Interview with | ١ | BETHES    | DA HEALTH CARE C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |            | 4   | 44 ONE ELEVEN PLACE                                                                                                                |                      |                   |    |
| PREFIX TAG NEGUATORY OR LSC IDENTIFYNG INFORMATION)  F 315  Continued From page 12  The findings included:  Resident #30 was admitted to the facility on January 1, 2013, with diagnoses including Congestive Heart Failure, Attriemer's Disease, Dysphagia, Ameria, Rheumatold Arthritis, Esophageal Reflux, Insomnia, Chronic Kidney Disease, Lupus, and Vitamin D Deficiency.  Medical record review of the admission assessment revealed the resident was admitted to the hospital from December 11, 2012, to January 1, 2013.  Medical record review of a significant change MDS dated January 7, 2013, revealed the resident was feeded was feeded analyzed. 2013, at 7:55 a.m., on the 500 halfway, revealed the resident in a gerichair and very confused.  Interview with certified nurse assistant, (CNA) #1 on February 11, 2013, at 4:25 p.m. on 600 half revealed, CNAs check on the resident deep continent with assistance from the CNA."  Interview with MDS Coordinator #1 on February 1 breath and the property of the prope | ŀ | (X4) ID   | SUMMARY STA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | TEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | , <u>.</u> |     |                                                                                                                                    |                      |                   |    |
| The findings included:  The findings included:  Resident #30 was admitted to the facility on January 1, 2013, with diagnoses including Congestive Heart Failure, Alzheimer's Disease, Dysphagia, Anemia, Rheumatoid Arthritis, Esophageal Reflux, Insomnia, Chronic Kidney Disease, Lupus, and Vitamin D Deficiency.  Medical record review of the admission assessment revealed the resident was admitted to the hospital from December 11, 2012, to January 1, 2013.  Medical record review of the Admission Minimum Data Set (MDS) dated Decamber 4, 2012, revealed the resident was admitted to the hospital from December 11, 2012, to January 7, 2013, revealed the resident change MDS dated January 7, 2013, revealed the resident was frequently inconfinent (7 or more episodes of urinary inconfinence).  Observation and interview with the resident on February 6, 2013, at 7:65 a.m., on the 600 hallway, revealed the resident in a gerichair and very confused.  Interview with certified nurse assistant, (CNA) #1 on February 11, 2013, at 4:25 p.m. on 600 hall revealed, CNAs check on the resident every 2 hours, and "lately the resident had been continent with assistance from the CNA."                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |   | PREFIX    | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | MUST BE PRECEDED BY FILL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | PREFI      |     | (EACH CORRECTIVE ACTION SHO<br>CROSS REFERENCED TO THE APPR                                                                        | UÉD BE               |                   | N. |
| Resident #30 was admitted to the facility on January 1, 2013, with diagnoses including Congestive Heart Failure, Alzheimer's Disease, Dysphagia, Anemia, Rheumatoid Arthritis, Esophageal Reflux, Insomnia, Chronic Kidney Disease, Lupus, and Vitamin D Deficiency.  Medical record review of the admission assessment revealed the resident was admitted to the hospital from December 11, 2012, to January 1, 2013.  Medical record review of the Admission Minimum Data Set (MDS) dated December 4, 2012, revealed the resident was admitted to the hospital from December 11, 2012, to January 1, 2013.  Medical record review of a significant change MDS dated January 7, 2013, revealed the resident was frequently incontinent (7 or more episodes of urinary incontinence).  Observation and interview with the resident on February 6, 2013, at 7:55 a.m., on the 600 hallway, revealed the resident in a gerichair and very confused.  Interview with certified nurse assistant, (CNA) #1 on February 11, 2013, at 4:25 p.m. on 600 hall revealed, CNAs check on the resident every 2 hours, and "lately the resident had been continent with assistance from the CNA."                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |   | F 315     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | F3         | 15  | of Nursing, and Staffing Coordinator will or weekly audits X30 days, if compliance is m decrease audits to morthly X3 months. Fire | omplete<br>aintained |                   |    |
| Interview with MDS Coordinator #1 on February 11, 2013, at 4:04 p.m., in the MDS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |   |           | Resident #30 was an January 1, 2013, with Congestive Heart Fa Dysphagia, Anemia, Esophageal Reflux, Disease, Lupus, and Medical record reviet assessment revealed to the hospital from I January 1, 2013.  Medical record reviet Data Set (MDS) date revealed the resident from December 11, 2 Medical record reviet MDS dated January 1 resident was frequent episodes of urinary in Observation and interfebruary 6, 2013, at 1 mallway, revealed the very confused.  Interview with certified on February 11, 2013 evealed, CNAs checknours, and "lately the | dmitted to the facility on the diagnoses including silure, Alzheimer's Disease, Rheumatoid Arthritis, Insomnia, Chronic Kidney I Vitamin D Deficiency.  We of the admission of the resident was admitted December 11, 2012, to the work of the Admission Minimum and December 4, 2012, to was admitted to the hospital 2012, to January 1, 2013.  We of a significant change 7, 2013, revealed the try incontinent (7 or more accontinence).  The with the resident on 7:55 a.m., on the 600 resident in a gerichair and the nurse assistant, (CNA) #1, at 4:25 p.m. on 600 hall to on the resident every 2 resident had been continent. |            |     | weekly audits X30 days, if compliance is medecrease audits to monthly X3 months. Fin                                               | aintained            | 02/23/13          |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |   | 1         | nterview with MDS Co<br>1, 2013, at 4:04 p.m.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | oordinator #1 on February<br>, in the MDS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |            |     |                                                                                                                                    |                      |                   |    |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICARD SERVICES

FORM APPROVED
OMB NO 0938-0301

|   | STATEMEN      | IT OF DEFICIENCIES                                                                                                                                                                                                                           | A MEDICAID SERVICES                                                                                                                                                                              | <del></del>     |                                       | <u> </u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | OMB N                                   | O. 0938-039                | ) |
|---|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|----------------------------|---|
|   | AND PLAN      | OF CORRECTION                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                            | (X2) N<br>A. BU |                                       | IPLE CONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X3) DATE                               |                            |   |
|   |               | ·                                                                                                                                                                                                                                            | 445427                                                                                                                                                                                           | B. WI           | 1G_                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 02                                      | 12/2013                    |   |
| J | NAME OF E     | PROVIDER OR SUPPLIER                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                 | QTD                                   | REET ADDRESS, CITY, STATE, ZIP CODE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1 021                                   | 12/2013                    | _ |
|   | BETHES        | DA HEALTH CARE C                                                                                                                                                                                                                             | ENTER                                                                                                                                                                                            | . [             | 44                                    | 44 ONE ELEVEN PLACE OOKEVILLE, TN 38501                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                         |                            |   |
| ŀ | (X4) ID       | SUMMARY STA                                                                                                                                                                                                                                  | TEMENT OF DEFICIENCIES                                                                                                                                                                           | <u> </u>        | <del>~</del>                          | ·                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                         |                            | _ |
|   | PRÉFIX<br>TAG | (EACH DEFICIENCY                                                                                                                                                                                                                             | MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                          | PREFI<br>TAG    |                                       | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOIL<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ULD BE                                  | (XS)<br>COMPLETION<br>DATE |   |
|   | F 315         | Coordinators' office, declined after return                                                                                                                                                                                                  | confirmed the resident had ing from the hospital, and                                                                                                                                            | F3              | 15                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                            |   |
|   | F 329         | was incontinent after<br>Further interview cor<br>assessment was to a<br>declined, or<br>upon readmission at<br>bladder assessment                                                                                                           | r re-admission to the facility. ofirmed, a bladder be done on all residents who ter a hospital stay, and a                                                                                       | F 32            | 20                                    | 492.25/0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                         |                            |   |
|   | SS=D          | UNNECESSARY DR                                                                                                                                                                                                                               | RUGS                                                                                                                                                                                             | F 32            | ,<br>(a                               | 483.25(l) Drug Regimen Is Free From Unnecessary Dr SS=D                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ugs                                     |                            |   |
|   |               | unnecessary drugs. drug when used in exduplicate therapy); or without adequate moindications for its use adverse consequences should be reduced or combinations of the resident, the facility may be a diagnosed and dorecord; and residents | easons above.  ensive assessment of a nust ensure that residents ntipsychotic drugs are not less antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic |                 |                                       | Requirement: Each resident's drug regimen will be free frouncessary drugs. The facility will ensure the residents who have not used antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the dinical record.  Corrective Action:  1. (a) On 2/10/13 Director of Nursing address behavior monitoring sheets for resident #57 arresident #135 in relation to the antipsychotic medications which both residents were taking (b) On 2/13/13 Director of Nursing contact physician and received order to decrease the Aresident #57, in accordance with the required a dose reduction.  2. On 2/23/13 Director of Nursing and Assist Director of Nursing and Direc | bat orgs c e scd the and tod billify on |                            |   |
|   |               | drugs receive gradual<br>pehavioral intervention                                                                                                                                                                                             | dose reductions, and                                                                                                                                                                             |                 | i i i i i i i i i i i i i i i i i i i | Director of Nursing conducted audit of resident antipsychotic medications for accuracy of behamonitoring sheets and for appropriate dosage reductions.  3. On 2/23/13 inservice was conducted by Directorian with nursing personnel regarding the monitoring of targeted behaviors for residents in unitsychotic medications as well as attempting lose reductions for residents on antipsychotic medications.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ats on<br>avior<br>ector of             |                            |   |
|   |               | This REQUIREMENT                                                                                                                                                                                                                             | is not met as evidenced                                                                                                                                                                          |                 |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                         |                            |   |

| CENT                     | ERS FOR MEDICARI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | E & MEDICAID SERVICES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                    |          |                                                                                         | FOR                        | M APPROVE<br>O. 0938-039   |
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| STATEME                  | ENT OF DEFICIENCIES<br>N OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) A<br>A. BU    |          | LTIPLE CONSTRUCTION<br>DING                                                             | (X3) DATE                  |                            |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 445427                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | B. WII             | NG       |                                                                                         | 1                          |                            |
| NAME OF                  | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                    | <u>۔</u> | TOTAL DOUBLE OF STATE OF SERVICE                                                        |                            | /12/2013                   |
| BETHE                    | SDA HEALTH CARE C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                    | l        | TREET ADDRESS, CITY, STATE, ZIP COE<br>444 ONE ELEVEN PLAGE<br>COOKEVILLE, TN 38501     | E                          |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFI<br>TAG | ıx       | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE                   | (X5)<br>COMPLETION<br>DATE |
| F 329                    | by: Based on medical and interview, the fe adequate monitoring residents receiving atwo residents receiving attempt gradual dos antipsychotic medicaten residents review  The findings include Resident #57 was ad January 25, 2012, w Diabetes Mellitus Ty Stage Three Sacral Hypertension, Bipola and Anorexia.  Medical record review Data Set (MDS) date revealed the resident assistance with all Ad (ADLs) and was seve Medical record review June 13, 2012, reveal (milligrams) po (by medical record review care plan revealed " mood/behaviors and (psychlatric) med use resident's current care intervention as: "Stamood/behaviors or children intervention intervention as: "Stamood/behaviors or children intervention int | record review, observation acility failed to provide g of targeted behaviors for antipsychotic medication for and #135) and failed to be reduction (GDR) of an action for one resident (#57) of red.  d:  dmitted to the facility on ith diagnoses including type 2, Aspiration Pneumonia, Ulcer, Dementia, or Disorder, Hypothyroidism, or Disorder, Hypothyroidism, are provided to the Quarterly Minimum and November 12, 2012, the requires extensive estivities of Daily Living erely cognitively impaired.  W of physician's orders dated alled "restart Ability 5 mg outh) at his (hour of sleep)."  W of the resident's current are resident at risk for side effects of psych and revealed the | F3                 | 1        | ·                                                                                       | ocial Services 30 days, if | 02/23/13                   |
|                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                    |          |                                                                                         |                            | j                          |

| CEN                     | TERS FOR MEDICARI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | E & MEDICAID SERVICES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                    |                   |                                                                                                            | FO       | RM APPROVE                        |
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| PINCEN                  | ENT OF DEFICIENCIES<br>AN OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | - 1                | MULTIPI<br>ILDING | E CONSTRUCTION                                                                                             | (X3) DAT | IO. 0938-039<br>ESURVEY<br>PLETED |
|                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 445427                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | B. WI              | √G                |                                                                                                            |          | V/4.0/00.40                       |
| NAMEC                   | F PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                    | STREE             | T ADDRESS, CITY, STATE, ZIP CODE                                                                           | <u> </u> | 2/12/2013                         |
| BETH                    | ESDA HEALTH CARE C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                    | 444               | ONE ELEVEN PLACE<br>OKEVILLE, TN 38501                                                                     |          |                                   |
| (X4) II<br>PREFI<br>TAG | X I (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFU<br>TAG | x                 | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRI<br>DEFICIENCY) | ILD BE   | (X5)<br>COMPLETION<br>DATE        |
| F 32                    | MARs (Medication attached Behavior Manuary 2011, for the revealed no targeted check-mark in the bonly"  Continued medical moders from June 3, revealed no physicial Dose Reduction (Gomedication.  Observations of the in the resident's room revealed the resident's room revealed the resident back, and watching the on February 6, 2013, 3:18 p.m., revealed the flat on back, and apposervations of the rin the resident's room resident laying in the across lap eating breaches laying in the across lap eating breached the resident over-bed table across laterview with the Direfebruary 7, 2013, at 10 office, confirmed antiphave targeted behavion Behavior Monitoring February 7 monitoring was to occ. | Administration Record) with Monitoring Flowsheet, revised the month of February 2013, discharges to monitor and a ox "Monitor Side Effects are cord review of physican's 2012, to February 11, 2013, an orders to attempt Gradual DR) of Abilify, an antipsychotic resident on February 6, 2013, and 7:55 a.m. and 9:20 a.m., at 1aying in the bed, flat on 7. Observation of the resident 1, in the resident's room, at 1, he resident laying in the bed, leared to be sleeping.  The resident on February 7, 2013, and 7:50 a.m., revealed the bed with over-bed table asident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with sident at 12:25 p.m., laying in the bed with side | F3                 | 29                |                                                                                                            |          |                                   |

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTEU: 02/14/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING 445427 02/12/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BETHESDA HEALTH CARE CENTER 444 ONE ELEVEN PLACE COOKEVILLE, TN 38501 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION łD PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 329 Continued From page 16 F 329 Interview with the DON on February 11, 2013, at 4:26 p.m., in the DON's office, confirmed no gradual dose reduction (GDR) of an antipsychotic medication had been attempted, and no documentation from the physician a GDR was not possible, since the initiation of the resident's antipsychotic medication on June 3, 2012. Resident #135 was admitted to the facility on May 5, 2011, with diagnoses including Status Post (after) Fall, Hypertension, Anemia, Anxiety, Depression, and Severe End-Stage Alzheimer's Disease. Medical record review of the Quarterly Minimum Data Set (MDS) dated November 23, 2012, revealed the resident required extensive assistance with all activities of daily living (ADLs) and was severely cognitively impaired. Observation of the resident on February 6, 2013, in the resident's room, at 9:00 a.m., revealed the resident in a reclined Geri-chair and appeared to be sleeping. Continued observation of the resident on February 6, 2013, at 10:55 a.m., revealed the resident in a reclined Geri-chair in the hallway outside of the resident's room and was alert, however did not speak. Medical record review of the resident's current care plan revealed "...Resident at risk for mood/behaviors and side effects of psych med use to manage mood/behaviors..." Continued

review of the resident's current care plan revealed

intervention as "...Staff to monitor for any mood/behaviors or changes in mood or behaviors, assess for possible underlying

| CENT                                                                                                | ERS FOR MEDICARI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  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| NAME OF                                                                                             | PROVIDER OR SUPPLIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             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| BETHE                                                                                               | SDA HEALTH CARE C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ENTER                                                                                                                                                                                                                                                                                                                                                                                                    |                               | 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | REET ADDRESS, CITY, STATE; ZIP CODE<br>144 ONE ELEVEN PLAGE<br>COOKEVILLE, TN 38501                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |         |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                            | . I (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                        | ID<br>PREFI<br>TAG            | <u></u> -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLL CROSS-REFERENCED TO THE APPROPRIES OF THE PROPRIES OF | JLD RF  | (X5)<br>COMPLETION<br>DATE |
| F 329                                                                                               | Continued From pa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                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|                                                                                                     | MARS (Medication A attached Behavior M January, 2011, for the revealed no targeted documentation for some support of the targeted behave the targeted behave behavior Monitoring monitoring was to occurred for the resident occur | rector of Nursing (DON) on 10:46 a.m., in the DON's ipsychotic medication was to iors documented on Flowsheet and behavior cur. Continued interview ned no behavior monitoring dent. DCURE, SERVE - SANITARY  In sources approved or my by Federal, State or local stribute and serve food ions  is not met as evidenced in and interview the facility ary storage of food in one of cent refrigerators. |                               | Garage Control of the | 483.35(i) Food Procure, Store/Prepare/Serve - Sanitary SS=B Requirement: The facility will (1) procure food from sources approved or considered satisfactory by Federal, State, or local authorities; and (2) store, prepare distribute and serve food under sanitary condition.  Corrective Action: On 2/12/13 items identified as not having lab lates in the nourishment room refrigerator were emoved by the Dictitian. On 2/12/13 the Dictitian conducted an audit of effigerators within the facility to ensure that the coother open items without labels and dates. On 2/15/13 inservice conducted by Administrith facility staff regarding the placement of laborates on items which have been opened and place frigerators.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | els and |                            |
|                                                                                                     | The findings included:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/14/2013 FORM APPROVED OMB NO. 0938-0391

| STATEME       | NT OF DEFICIENCIES                                                                                                                      | CO DOORDER OF THE OF TH |                    |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | OMB NO. 0938-039<br>(X3) DATE SURVEY<br>COMPLETED |                            |  |
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| AND PLAN      | OF CORRECTION                                                                                                                           | (X1) PROVIDER/SUPPLIER/GLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) N<br>A. BU    |     | TIPLE CONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                   |                            |  |
| <u>L</u>      |                                                                                                                                         | 445427                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | B. WI              |     | <del></del>                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1                                                 |                            |  |
| NAME OF       | PROVIDER OR SUPPLIER                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                    |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 02                                                | /12/2013                   |  |
| •             | SDA HEALTH CARE C                                                                                                                       | ENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                    | 4   | REET ADDRESS, CITY, STATE, ZIP CODE<br>144 ONE ELEVEN PLACE                                                                                                                                                                                                                                                                                                                                                                                                      |                                                   | ·                          |  |
| (X4) ID       | SHUMADY STA                                                                                                                             | TEMENT OF DEFICIENCIES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                    | (   | COOKEVILLE, TN 38501                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                   |                            |  |
| PREFIX<br>TAG | ICAUTI DEFICIENCY                                                                                                                       | MUST BE PRECEDED BY FULL G IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOT<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                         | ULO RE                                            | (X5)<br>COMPLETION<br>DATE |  |
| F 371         | Observation of the s<br>nourishment refriger<br>2:50 p.m., revealed:                                                                    | outh hall resident<br>ator on February 11, 2013, at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | F3                 | 371 | 4. The facility Director of Nursing, Assistant of Nursing, Staffing Coordinator, and Dietiticomplete weekly audits X30 days, if complia maintained decrease audits to monthly X3 markings will be reviewed in Quality Assurant Committee.                                                                                                                                                                                                                        | an will<br>nice is                                |                            |  |
| į             | 2. a half pint contains opened and not labe 3. two one liter contains one-third full, opened 4. a ten ounce contain opened and not labe | er of whole milk, half full,<br>led<br>iners of bottled water<br>I and not labeled<br>ner of orange juice half full,<br>ed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                    |     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                   | 02/15/13                   |  |
| F 412<br>SS=D | beverages should be labeled with the resid 483.55(b) ROUTINE/ SERVICES IN NFS                                                           | EMERGENCY DENTAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | F 41               |     | 483.55(b) Routine/Emergency Dental Services in NFS SS=D                                                                                                                                                                                                                                                                                                                                                                                                          |                                                   |                            |  |
|               | §483.75(h) of this par covered under the Sta dental services to me resident; must, if necemaking appointments:                          | t, routine (to the extent the plan); and emergency et the needs of each essary, assist the resident in and by arranging for rom the dentist's office; and sidents with lost or                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                    |     | Requirement: The facility will provide or obtain from an outs resource routine and emergency dental services meet the needs of each resident. The facility wassist the resident in making appointments; and arranging for transportation to and from the desoffice; and will promptly refer residents with ledamaged dentures to a dentist.  Corrective Action: 1. On 27/1/13 Social Services Director contacter regarding resident #57 and resident #135. On 3. | s to ill l by ntist's set or d dentist            |                            |  |
| ا             | oy:<br>Based on medical rec<br>and interview the facili                                                                                 | is not met as evidenced ord review, observation, y failed to provide routine (#57 and #135) of three                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                    |     | resident #57 was seen by a deutist at the facility<br>2/25/13 resident #135 was seen by deutist at the<br>2. On 2/22/13 Social Services Director perform<br>of residents to ensure that residents who require<br>intervention were identified to be seen.                                                                                                                                                                                                        | facility.                                         |                            |  |

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/14/2013 FORM APPROVED OMB NO. 0938-0391

| STATEMEN               | NT OF DEFICIENCIES                                                 | (V4) PROMPED CHERTIES                                                                                                   |                    |    | <del></del>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | TOWR L   |                            |  |  |
|------------------------|--------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|--------------------|----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|----------------------------|--|--|
| AND PLAN OF CORRECTION |                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                   | (X2) N<br>A. BU    |    | TIPLE CONSTRUCTION NG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |          | SURVEY<br>PLETED           |  |  |
|                        | 445427 B. WING                                                     |                                                                                                                         |                    |    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |                            |  |  |
| NAME OF                | PROVIDER OR SUPPLIER                                               |                                                                                                                         | <del>  </del>      |    | THE LOCAL COLUMN TO THE COLUMN | 02       | /12/2013                   |  |  |
| BETHES                 | SDA HEALTH CARE C                                                  | ENTER                                                                                                                   |                    | 4  | REET ADDRESS, CITY, STATE, ZIP CODE<br>144 ONE ELEVEN PLACE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |                            |  |  |
| (X4) ID                | Cimerania                                                          |                                                                                                                         |                    | (  | COOKEVILLE, TN 38501                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |          |                            |  |  |
| PREFIX<br>TAG          | I IEWOU DEFICIENCY                                                 | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                       | ID<br>PRÉFI<br>TAG |    | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO)<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | JI O RE  | (X5)<br>COMPLETION<br>DATE |  |  |
| F 412                  | Continued From pa                                                  | no 10                                                                                                                   | [                  |    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |                            |  |  |
|                        | residents reviewed.                                                |                                                                                                                         |                    | 12 | 3. On 2/25/13 inservice was conducted by                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |          |                            |  |  |
|                        | The findings include<br>Resident #57 was a<br>25, 2012, with diagn | dmitted to the facility January                                                                                         |                    |    | Administrator with Social Services Director need to have residents seen timely by dentist 4. The facility Social Services Director will monthly audits X4 months, if compliance is decrease audits to quarterly. Findings will be in Quality Assurance Committee.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | complete |                            |  |  |
| ,                      | Congestive Heart Fa                                                | allure, Anemia, Chronic<br>ary Disease, and Failure to                                                                  |                    |    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          | 03/23/13                   |  |  |
|                        | (MDS) dated June 4                                                 | w of a Minimum Data Set<br>, 2012, revealed the resident<br>ely cavity or broken natural                                |                    |    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |                            |  |  |
|                        | several missing and                                                | uary 4, 2013 at 4:06 p.m., in revealed the resident had broken teeth. Interview with ime, revealed the resident m pain. |                    |    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |                            |  |  |
|                        | repruary 7, 2013, at<br>nurses station, reveal                     | cial Services Director on<br>1:35 p.m., at the south wing<br>led the resident's dental<br>on admission, but had not     |                    |    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |                            |  |  |
|                        | o, 2011, with diagnose<br>after) Fall, Hypertens                   | Imitted to the facility on May es including Status Post ion, Anemia, Anxiety, ere End-Stage Alzheimer's                 |                    |    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          |                            |  |  |
| Te I                   | ਾਕਾਬ Set (MDS) dated<br>evealed the resident।                      | of the Quarterly Minimum<br>November 23, 2012,<br>required extensive<br>vities of daily living (ADLs)                   |                    |    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |          | *                          |  |  |

| <u>CEN</u>                                   | TERS FOR MEDICARI                                                                                                                                                                                                                                                                                                                                                                                                                                                           | HAND HUMAN SERVICES  E & MEDICAID SERVICES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     |                                                                              | FOR                                | M APPROVED                      |
|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|------------------------------------------------------------------------------|------------------------------------|---------------------------------|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) M(             | ULTIPLE CONSTRUCTION DING                                                    | (X3) DATE                          | O. 0938-0391<br>SURVEY<br>LETED |
|                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 445427                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | B. WIN              | G                                                                            | <br>-   an:                        | 40/0040                         |
| BETH                                         | F PROVIDER OR SUPPLIER ESDA HEALTH CARE C                                                                                                                                                                                                                                                                                                                                                                                                                                   | ENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                     | STREET ADDRESS, CITY, STATE,<br>444 ONE ELEVEN PLACE<br>COOKEVILLE, TN 38501 |                                    | 12/2013                         |
| (X4) I<br>PREF<br>TAG                        | X   (EACH DEFICIENC)                                                                                                                                                                                                                                                                                                                                                                                                                                                        | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN (<br>(EACH CORRECTIVE A<br>CROSS-REFERENCED TO<br>DEFICIE    | CTION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETION<br>DATE      |
| F 4*                                         | and was severely of the rin the resident's roo resident in a recline be sleeping. Conting resident on Februar revealed the resident the hallway outside was alert, however of observation of the remultiple missing tee and two upper front black and worn down Medical record reviet order dated March 4 referral-missing teets. Continued medical recare plan dated March "Social Services re (related to) missing to revealed no documer provided or of the residentist. | resident on February 6, 2013, m, at 9:00 a.m., revealed the d Geri-chair and appeared to used observation of the y 6, 2013, at 10:55 a.m., at in a reclined Geri-chair in of the resident's room and fid not speak. Continued esident at that time revealed, th on the bottom of mouth teeth which were noted to be n.  We revealed a physician's y. 2012 "Dental n, carries"  Decord review of the resident's ch 14, 2012, revealed ferral for dental consult r/t eeth/carries"  The resident's medical record ntation of a dental consult sident being examined by a | F 41                | 12                                                                           |                                    |                                 |
| F 428<br>SS≃D                                | 2013, in the hallway of room, at 10:25 a.m., of not been seen by a dimade and, "it's my table 1483.60(c) DRUG REC                                                                                                                                                                                                                                                                                                                                                           | Services on February 6, butside of the Main Dining confirmed the resident had entist after the referral was faultit didn't get done"  SIMEN REVIEW, REPORT N                                                                                                                                                                                                                                                                                                                                                                                                           | F 428               | 483.60(c) Dnig Regimen Review, Report SS≕D                                   | 1<br>                              |                                 |

The drug regimen of each resident must be

CHARLIMENT OF REALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445427 02/12/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BETHESDA HEALTH CARE CENTER 444 ONE ELEVEN PLACE COOKEVILLE, TN 38501 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY F 428 | Continued From page 21 F 428 Requirement: reviewed at least once a month by a licensed The drug regimen of each resident will be reviewed at least once a month by a licensed pharmacist. pharmacist. The pharmacist will report any irregularities to the attending physician, and The pharmacist must report any irregularities to the director of nursing, and these reports will the attending physician, and the director of be acted upon. nursing, and these reports must be acted upon. Corrective Action: 1. On 2/13/13 Assistant Director of Nursing contacted physician for resident #57 and had pharmacy recommendations addressed properly. 2. On 2/23/13 Director of Nursing and Assistant Director of Nursing performed audit to ensure This REQUIREMENT is not met as evidenced recommendations made by pharmacy for residents of facility were addressed timely by attending physicians. Based on medical record review, facility 3. On 2/25/13 inservice conducted by Administrator documentation review and interview, the facility with Director of Nursing and Assistant Director of Nursing concerning need to have pharmacy failed to act upon a recommendation from the recommendations addressed timely by residents consultant pharmacist for one resident (#57) of attending physician. thirty-eight residents reviewed. 4. The facility Director of Nursing, Assistant Director. of Nursing, and Staffing Coordinator will complete weekly audits X30 days, if compliance is maintained decrease audits to monthly X3 months. Findings will The findings included: be reviewed in Quality Assurance Committee. Resident #57 was admitted to the facility on January 25, 2012, with diagnoses including 02/25/13 Diabetes Mellitus Type 2, Aspiration Pneumonia, Stage Three Sacral Ulcer, Dementia, Hypertension, Bipolar Disorder, Hypothyroidism. and Anorexia. Medical record review of physician's orders dated June 13, 2012, revealed "restart Abilify 5 mg (milligrams) po (by mouth) at hs (hour of sleep)." Review of facility documentation provided by the Director of Nursing (DON) revealed a "Note to Attending Physician/Prescriber" from the consultant pharmacist.

| CENTE                                                    | RS FOR MEDICARI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | & MEDICAID SERVICES                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                   |      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                    |          | 9938-0391                  |
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| STATEMENT OF DEFICIENCIES (XI)<br>AND PLAN OF CORRECTION |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (XI) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                    | (X2) N<br>A. BU   |      | IPLE CONSTRUCTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X3) DAT                                                           |          | RVEY                       |
|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 445427                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | B. Wil            | NG_  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                    | 19/49    | /2013                      |
|                                                          | PROVIDER OR SUPPLIER  DA HEALTH CARE C                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>.1</b>         | 4    | REET ADDRESS, CITY, STATE, ZIP CODE<br>44 ONE ELEVEN PLACE<br>COOKEVILLE, TN 38501                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 10                                                                 | <u> </u> | 72013                      |
| (X4) ID<br>PREFIX<br>TAG                                 | (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREF<br>TAG |      | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | OULD BE                                                            |          | (X5)<br>COMPLETION<br>DATE |
| F 507<br>SS=D                                            | Continued review of Physician/Prescribe of December 14, 20 medications need to resident is on abilify day). Please review possible"  Further review of the Physician/Prescribe response from the accontinued review response Requires Chart."  Interview with the Dinarding physician recommendation from 483.75(j)(2)(iv) LAB LAB NAME/ADDRE  The facility must file record laboratory reponded to the name and laboratory.  This REQUIREMEN by:  Based on medical rethe facility failed to perform the faci | of the "Note to Attending er" dated with a "faxed" stamp 212, revealed "antipsychotic to be tapered periodicallythe of 5 mg (milligrams) qd (every of the case and taper if the "Note to Attending er" revealed no signature or attending prescriber. Evealed a stamp, "A NO is Clinical Documentation in the consultant pharmacist. REPORTS IN RECORD - SS  In the resident's clinical ports that are dated and address of the testing the resident (#127) of reviewed. | F 50              |      | 483.75(j) (2)(iv) Lab Reports in Record – Lab Name/Address SS=D  Requirement: The facility will file in the resident's clinical laboratory reports that are dated and contain and address of the testing laboratory.  Corrective Action: 1. On 27/13 lab report for resident #127 was by Assistant Director of Nursing and sent to physician for review. 2. On 2/23/13 Director of Nursing and Assis Director of Nursing conducted audit of residence and the sent to physician for received on a daily basis. 3. On 2/23/13 inservice conducted by Director of Nursing with nursing personnel concerning the review of lab results. Lab results are to be all review of lab results. Lab results are to be all review of lab results. Lab results are to be all | record the name s obtained attending stant ent lab or of ac timely |          |                            |
|                                                          | THE HIMMAS HIMME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | y.                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                   | ٠, ا | resident's medical record in a timely fashion to<br>to have appropriate follow-up.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | and need                                                           |          |                            |

| CENTE                                                    | RS FOR MEDICARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | & MEDICAID SERVICES                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | M APPROVED                 |  |
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| STATEMEN                                                 | IT OF DEFICIENCIES<br>OF CORRECTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X2) MULT<br>A. BUILDI                                                              | TIPLE CONSTRUCTION NG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED |                            |  |
|                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 445427                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | B. WING                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | 4010040                    |  |
| NAME OF PROVIDER OR SUPPLIER BETHESDA HEALTH CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | REET ADDRESS, CITY, STATE, ZIP CODE<br>144 ONE ELEVEN PLACE<br>COOKEVILLE, TN 38501 | 1 02/                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 12/2013                       |                            |  |
| (X4) ID<br>PREFIX<br>TAG                                 | I (EACH DEFICIENCY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                 | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ULD BE                        | (X5)<br>COMPLETION<br>DATE |  |
|                                                          | Resident #127 was December 10, 2010 COPD (Chronic Obside Malaise, DM2 (Diab (history) Prostate Compartinson's, and Parkinson's, and Parkinson' | admitted to the facility on with diagnoses including structive Pulmonary Disease), etes Mellitus 2), Anxiety, hx A (cancer), Hypercholesterol, are, HTN (hypertension), ranoid Schizophrenia.  We of the Physician orders 2012, revealed "Vitamin D." Further review of the orders ated January 3, 2013, hths (resume lab)"  We of the laboratory reports tion for Vitamin D was at 12, 2012, with results lts noted in the medical ector of Nursing (DON), and Nursing (ADON), in the DON | F 507                                                                               | 4. The facility Director of Nursing, Assist of Nursing, and Staffing Coordinator will of weekly audits X30 days, if compliance is a decrease audits to monthly X3 months. Finds the reviewed in Quality Assurance Committee of the complete of the control of the con | complete<br>naintained        | 02/23/13                   |  |